

**Adopt Part Ins 1901, to read as follows:**

**PART Ins 1901 MINIMUM STANDARDS FOR ACCIDENT AND HEALTH INSURANCE**

Statutory Authority: RSA 400-A:15; RSA 415-A:2; RSA 420-A:20; RSA 420-B:21

**Ins 1901.01 Purpose.** The purpose of this rule is to implement the provisions of RSA 415-A, RSA 420-A and RSA 420-B to standardize and simplify the terms and coverages of individual accident and health insurance policies and group supplemental health insurance policies and certificates. This rule is also intended to facilitate public understanding and comparison of coverage, to eliminate provisions contained in individual accident and health insurance policies and group supplemental health insurance that may be misleading or confusing in connection with the purchase of the coverages or with the settlement of claims; and to provide for full disclosure in the marketing and sale of individual accident and health insurance policies and group supplemental health insurance. This rule is also intended to assert the commissioner's jurisdiction over dental and vision plans, and to provide for disclosure in the sale of those plans.

**Ins 1901.02 Applicability and Scope.** This rule applies to all individual and group supplemental accident and health insurance policies and certificates, delivered or issued for delivery in this state on and after the effective date of this rule, with the exception of policies of long-term care insurance under RSA 415-D and policies of Medicare supplemental insurance subject to RSA 415-F.

**Ins 1901.03 Definition of Group Supplemental Health Insurance** "Group Supplemental Health Insurance" includes any policy, issued to a group in accordance with RSA 415:18, which provides health insurance coverage other than group policies of –hospital, surgical or medical expense coverage. This term includes, but is not limited to: certificates providing hospital confinement indemnity, accident only, accidental death and dismemberment, Champus/Tricare supplemental, specified disease, limited benefit, dental, disability income, prescription drug, travel, or vision coverage.

**Ins 1901.04 Policy Definitions.**

(a) Except as provided in this rule, an individual or group supplemental accident and health insurance policy or certificate delivered or issued for delivery to any person in this state and to which this rule applies shall contain definitions respecting matters set forth below that comply with the requirements of this section.

(b) "Accident," "accidental injury," and "accidental means" shall be defined to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(1) The definition shall not be more restrictive than the following: "injury" or "injuries" means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause and that occurs while the insurance is in force.

(2) The definition may provide that injuries shall not include injuries for which benefits are provided under workers' compensation, employers' liability or similar law; or under a motor vehicle no-fault plan, unless prohibited by law; or injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit.

(c) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall be defined in relation to its status, facility and available services.

(1) A definition of the home or facility shall not be more restrictive than one requiring that it:

- a. Be operated pursuant to law;
- b. Be approved for payment of Medicare benefits or be qualified to receive approval for payment of Medicare benefits, if so requested;
- c. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;
- d. Provide continuous 24 hour-a-day nursing service by or under the supervision of a registered nurse; and
- e. Maintain a daily medical record of each patient.

(2) The definition of the home or facility may provide that the term shall not be inclusive of:

- a. A home, facility or part of a home or facility used primarily for rest;
  - b. A home or facility for the aged or for the care of drug addicts or alcoholics;
- or
- c. A home or facility primarily used for the care and treatment of mental diseases or disorders, or for custodial or educational care.

(d) "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Healthcare Organizations.

(1) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

- a. Be an institution licensed to operate as a hospital pursuant to law;
- b. Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and
- c. Provide 24 hour nursing service by or under the supervision of registered nurses.

(2) The definition of the term "hospital" may state that the term shall not be inclusive of:

- a. Convalescent homes or, convalescent, rest or nursing facilities;
- b. Facilities affording primarily custodial, educational or rehabilitary care;
- c. Facilities for the aged, drug addicts or alcoholics; or
- d. A military or veterans' hospital, a soldiers' home or a hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except for services rendered on an

emergency basis where a legal liability for the patient exists for charges made to the individual for the services.

(e) "Medicare" means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended.

(f) "Mental or nervous disorder" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind.

(g) "Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as registered nurse, a licensed practical nurse, or a licensed vocational nurse. If the words "nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the use of these terms requires the insurer to recognize the services of any individual who qualifies under the terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

(h) "One period of confinement" means consecutive days of in-hospital services received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than 90 days or 3 times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

(i) "Partial disability" shall be defined in relation to the individual's inability to perform one or more but not all of the "major," "important" or "essential" duties of employment or occupation, or may be related to a percentage of time worked or to a specified number of hours or to compensation.

(j) "Physician" may be defined by including words such as "qualified physician" or "licensed physician." The use of these terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when the services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(k) "Preexisting condition" shall not be defined more restrictively than the following: "Preexisting condition means the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a 2 year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a 2 year period preceding the effective date of the coverage of the insured person." Medical expense policies and certificates shall comply with RSA 420-G:7.

(l) "Residual disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important" or "essential duties" of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy that provides for residual disability benefits may require a qualification period, during which the insured shall be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or other terms of similar import that in the opinion of the commissioner adequately and fairly describes the benefit.

(m) "Sickness" shall not be defined to be more restrictive than the following: "Sickness means sickness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. - The definition may be further modified to exclude sickness or disease for which benefits are provided under a workers' compensation, occupational disease, employer's liability or similar law. Probationary periods shall not apply to policies or certificates issued pursuant to RSA 420-G.

(n) "Total disability"

(1) A general definition of total disability shall not be more restrictive than one requiring that the individual who is totally disabled not be engaged in any employment or occupation for

which he or she is or becomes qualified by reason of education, training or experience; and is not in fact engaged in any employment or occupation for wage or profit.

(2) Total disability may be defined in relation to the inability of the person to perform duties but shall not be based solely upon an individual's inability to:

- a. Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation;" or
- b. Engage in a training or rehabilitation program.

(3) An insurer may require the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation or words of similar import. An insurer may require care by a physician other than the insured or a member of the insured's immediate family.

**Ins 1901.05 Prohibited Policy Provisions.**

(a) Except as provided in Ins 1901.04 (k), an individual policy shall not contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy, subject to the further exception that a policy may specify a probationary or waiting period not to exceed 6 months for the following specified diseases or conditions and losses resulting from diseases or conditions related to: hernia disorder of reproduction organs, varicose veins, adenoids, appendix and tonsils. However, the permissible 6 month exception shall not be applicable where the specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.

(b) A policy or rider for additional coverage may not be issued as a dividend unless an equivalent cash payment is offered as an alternative to the dividend policy or rider. A dividend policy or rider for additional coverage shall not be issued for an initial term of less than 6 months.

(1) The initial renewal subsequent to the issuance of a policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that the renewal is optional.

(c) A policy or certificate shall not exclude coverage for a loss due to a preexisting condition for a period greater than 12 months following the issuance of the policy or certificate where the application or enrollment form for the insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment of the preexisting condition and is not specifically excluded by the terms of the policy or certificate. This provision shall not apply to policies or certificates issued pursuant to RSA 420-G.

(d) A disability income policy may contain a "return of premium" or "cash value benefit" so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy; and the insurer demonstrates that the reserve basis for the policies is adequate. No other policy subject to RSA 415-A and this rule shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.

(e) Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

(f) A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

- (1) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;
- (2) Mental or emotional disorders, alcoholism and drug addiction;
- (3) Pregnancy, except for complications of pregnancy, other than for policies defined in Ins 1901.06 (h) of this rule;
- (4) Illness, treatment or medical condition arising out of:
  - a. War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it;
  - b. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;
  - c. Aviation, except as a fare-paying passenger;
  - d. With respect to short-term nonrenewable policies, interscholastic sports; and
  - e. With respect to disability income protection policies, incarceration.
- (5) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect;
- (6) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;
- (7) Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column.
- (8) Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), a state or federal workers' compensation, employer's liability or occupational disease law, or motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance.
- (9) Dental care or treatment;
- (10) Eye glasses, hearing aids and examination for the prescription or fitting of them;
- (11) Rest cures, custodial care, transportation and routine physical examinations; and
- (12) Territorial limitations.

(g) Except that the provisions of RSA 420-G shall control for policies issued pursuant to that chapter, this rule shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page.

(h) Policy provisions precluded in this section shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions in accordance with RSA 415-A, RSA 420-A and RSA 420-B that in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy.

**Ins 1901.06 Accident and Health Minimum Standards for Benefits.** The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. An individual accident and health insurance policy or group supplemental health insurance policy shall not be delivered or issued for delivery in this state unless it meets the required minimum standards for the specified categories or the commissioner finds that the policies or contracts are approvable as limited benefit health insurance and the outline of coverage complies with the outline of coverage in Ins 1901.08 (l) of this rule.

This section shall not preclude the issuance of any policy or contract combining 2 or more categories set forth in RSA 415-A:3 I. and II.

(a) General rules.

(1) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" individual accident and health policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. In addition, the policy shall provide that in the event of the insured's death, the spouse of the insured, if covered under the policy, shall become the insured.

(2) The terms "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Ins 1901.07(a)(1); and

a. The terms "noncancellable" or "noncancellable and guaranteed renewable" shall be used only in accident and health policy or certificate that the insured has the right to continue in force by the timely payment of premiums set forth in the policy or certificate until the age of 65 or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

b. An accident and health or accident-only policy or certificate that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness shall provide that the insured has the right to continue the policy only to age 60 if, at age 60, the insured has the right to continue the policy in force at least to age 65 while actively and regularly employed.

c. Except as provided above, the term "guaranteed renewable" shall be used only in policy or certificate that the insured has the right to continue in force by the timely payment of premiums until the age of 65 or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.

(3) In an accident and health policy or certificate covering both husband and wife, the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the

stated age so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in the policy.

(4) When accidental death and dismemberment coverage is part of the accident and health insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.

(5) If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis.

(6) In the event the insurer cancels or refuses to renew, policies or certificates providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

(7) Policies providing convalescent or extended care benefits following hospitalization shall not condition the benefits upon admission to the convalescent or extended care facility within a period of less than 14 days after discharge from the hospital.

(8) Accident and health insurance policies or certificates coverages shall continue for a dependent child who is incapable of self-sustaining employment due to mental or physical handicap on the date that the child's coverage would otherwise terminate under the policy due to the attainment of a specified age for children and who is chiefly dependent on the insured for support and maintenance. The policy may require that within 31 days of the date the company receives due proof of the incapacity in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder.

(9) A policy or certificate providing coverage for the recipient in a transplant operation shall also provide reimbursement for any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid.

(10) A policy may contain a provision relating to recurrent disabilities; but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than 6 months.

(11) Accidental death and dismemberment benefits shall be payable if the loss occurs within 90 days from the date of the accident, irrespective of total disability. Disability income benefits, if provided, shall not require the loss to commence less than 30 days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time the disability commences if the accident occurred while the coverage was in force.

(12) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

(13) An accident-only policy or certificate providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.

(14) Termination of the policy or certificate shall be without prejudice to a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits.

(15) A policy or certificate providing coverage for fractures or dislocations shall not provide benefits only for "full or complete" fractures or dislocations.

(b) Basic Hospital Expense Coverage. "Basic hospital expense coverage" is a policy of accident and health insurance that provides coverage for a period of not less than 31 days during a continuous hospital confinement for each person insured under the policy, for expenses incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:

(1) Daily hospital room and board in an amount not less than the lesser of:

- a. Eighty percent of the charges for semiprivate room accommodations or
- b. One hundred dollars per day;

(2) Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies that are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either 80 percent of the charges incurred up to at least \$3,000 or 10 times the daily hospital room and board benefits; and

(3) Hospital outpatient services consisting of:

- a. Hospital services on the day surgery is performed,
- b. Hospital services rendered within 72 hours after injury, in an amount not less than \$150; and
- c. X-ray and laboratory tests to the extent that benefits for the services would have been provided in an amount of less than \$100 if rendered to an in-patient of the hospital.

(4) Benefits provided under paragraphs (1) and (2) of this subsection may be provided subject to a combined deductible amount not in excess of \$100.

(c) Basic Medical-Surgical Expense Coverage. "Basic medical-surgical expense coverage" is a policy or certificate of accident and health insurance that provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

(1) Surgical services:

- a. In amounts not less than those provided on a fee schedule based on the relative values contained in the current edition of the Current Procedure Terminology (CPT) coding or other acceptable relative value schedule, up to a maximum of at least \$1,000 for one procedure; or
- b. Not less than 80 percent of the reasonable charges.

(2) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or the physician assistant) performing the surgical services:

- a. In an amount not less than 80 percent of the reasonable charges; or
- b. Fifteen percent of the surgical service benefit.

(3) In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than 80 percent of the reasonable charges, or \$50 per day for not less than 21 days during one period of confinement.

(d) Basic Hospital/Medical-Surgical Expense Coverage. "Basic hospital/medical-surgical expense coverage" is a combined coverage and shall meet the requirements of both subsections (b) and (c).

(e) Hospital Confinement Indemnity Coverage.

(1) "Hospital confinement indemnity coverage" is a policy or certificate of accident and health insurance that provides daily benefits for hospital confinement on an indemnity basis in an amount not less than \$40 per day and not less than 31 days during each period of confinement for each person insured under the policy.

(2) Coverage shall not be excluded due to a preexisting condition for a period greater than 12 months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.

(3) Except for the NAIC uniform provision regarding other insurance with the insurer, benefits shall be paid regardless of other coverage.

(f) Major Medical Expense Coverage,

(1) "Major medical expense coverage" is an accident and health insurance policy or certificate that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than \$500,000; coinsurance percentage per year per covered person not to exceed 50% of covered charges, provided that the coinsurance out-of-pocket maximum after any deductibles shall not exceed \$10,000 per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed 5 percent of the aggregate maximum limit under the policy for each covered person for at least:

a. Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides;

b. Miscellaneous hospital services;

c. Surgical services;

d. Anesthesia services;

e. In-hospital medical services;

f. Out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provide elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and

g. Not fewer than 3 of the following additional benefits:

1. In-hospital private duty registered nurse services;

2. Convalescent nursing home care;

3. Diagnosis and treatment by a radiologist or physiotherapist;

4. Rental of special medical equipment, as defined by the insurer in the policy;

5. Artificial limbs or eyes, casts, splints, trusses or braces;

6. Treatment for functional nervous disorders, and mental and emotional disorders; or

7. Out-of-hospital prescription drugs and medications.

(2) The minimum benefits required by Ins 1901.07 (f) (1) may be subject to all applicable deductible, coinsurance and general policy exceptions and limitations. A major medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under Ins 1901.07 (l) g. and other such special or internal limitations as are authorized or approved by the commissioner. Except as authorized by this subsection through the application of special or internal limitations, a major medical expenses policy shall be designed to cover, after any deductibles or coinsurance provisions are met, the usual, customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.

(g) Basic Medical Expense Coverage.

(1) "Basic medical expense coverage" is an accident and health insurance policy or certificate that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than \$250,000; coinsurance percentage per year per covered person not to exceed 50 percent of covered charges, provided that the coinsurance out-of-pocket maximum after any deductibles shall not exceed \$25,000 per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed 10 percent of the aggregate maximum limit under the policy for each covered person for at least:

a. Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides or such other rate agreed to between the insurer and provider for a period of not less than 31 days during continuous hospital confinement;

b. Miscellaneous hospital services;

c. Surgical services;

d. Anesthesia services;

e. In-hospital medical services;

f. Out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy and hemodialysis ordered by a physician; and

g. Not fewer than 3 of the following additional benefits:

1. In-hospital private duty graduate registered nurse services;

2. Convalescent nursing home care;

3. Diagnosis and treatment by a radiologist or physiotherapist;
4. Rental of special medical equipment, as defined by the insurer in the policy.
5. Artificial limbs or eyes, casts, splints, trusses or braces;
6. Treatment for functional nervous disorders, and mental and emotional disorders; or
7. Out-of-hospital prescription drugs and medications.

(2) The minimum benefits required by Ins1901.07 (g)(1) may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. A basic medical expense policy or certificate may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under Ins 1901.07 (g)(1)g. and other such special or internal limitations as are authorized or approved by the commissioner. Except as authorized by this subsection through the application of special or internal limitations, an individual basic medical expense policy shall be designed to cover, after any deductibles or coinsurance provisions are met, the usual customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.

(h) Disability Income Protection Coverage. "Disability income protection coverage" is a policy or certificate that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them that:

(1) Provides that period payments that are payable at ages after 62 and reduced solely on the basis of age are at least 50 percent of amounts payable immediately prior to 62;

(2) Contains an elimination period no greater than:

- a. Ninety days in the case of a coverage providing a benefit of one year or less;
- b. One hundred and eighty days in the case of coverage providing a benefit of more than one year but not greater than 2 years; or
- c. Three hundred sixty five days in all other cases during the continuance of disability resulting from sickness or injury;

(3) Has a maximum period of time for which it is payable during disability of at least 6 months except in the case of a policy covering disability arising out of pregnancy, childbirth or miscarriage in which case the period for the disability may be one month. No reduction in benefits shall be put into effect because of an increase in social security or similar benefits during a benefit period. Ins 1901.07 (f) does not apply to those policies providing business buy-out coverage;

(4) Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

(i) Accident Only Coverage. "Accident only coverage" is a policy or certificate that provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care

caused by accident. Accidental death and double dismemberment amounts under the policy shall be at least \$1,000 and a single dismemberment amount shall be at least \$500.

(j) Specified Disease Coverage.

(1) "Specified disease coverage" pays benefits for the diagnosis and treatment of a specifically named disease or diseases. A specified disease policy shall meet the following rules and one of the following sets of minimum standards for benefits:

a. Insurance covering cancer only or cancer in conjunction with other conditions or diseases shall meet the standards of paragraphs (4), (5) or (6) of this subsection.

b. Insurance covering specified diseases other than cancer shall meet the standards of paragraphs (3) and (6) of this subsection.

(2) General Rules. Except for cancer coverage provided on an expense-incurred basis, either as cancer-only coverage or in combination with one or more other specified diseases, the following rules shall apply to specified disease coverages in addition to all other rules imposed by this rule. In cases of conflict between the following and other rules, the following shall govern:

a. Policies covering a single specified disease or combination of specified diseases shall not be sold or offered for sale other than as specified disease coverage under this section.

b. Any policy issued pursuant to this section that conditions payment upon pathological diagnosis of a covered disease shall also provide that if the pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead.

c. Notwithstanding any other provision of this rule, specified disease policies shall provide benefits to any covered person not only for the specified diseases but also for any other conditions or diseases, directly caused or aggravated by the specified diseases or the treatment of the specified disease.

d. Individual accident and health policies containing specified disease coverage shall be at least guaranteed renewable.

e. No policy issued pursuant to this section shall contain a waiting or probationary period greater than 30 days. A specified disease policy may contain a waiting or probationary period following the issue or reinstatement date of the policy or certificate in respect to a particular covered person before the coverage becomes effective as to that covered person.

f. An application or enrollment form for specified disease coverage shall contain a statement above the signature of the applicant or enrollee that a person to be covered for specified disease is not covered also by any Title XIX program (Medicaid, MediCal or any similar name). The statement may be combined with any other statement for which the insurer may require the applicant's or enrollee's signature.

g. Payments shall be conditioned upon an insured person's receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.

h. Except as otherwise specifically provided by statute, benefits for specified disease coverage shall be paid regardless of other coverage.

i. After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of care or confinement if the care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of the coverage shall not be less than 90 days prior to the diagnosis.

j. Policies providing expenses benefits shall not use the term "actual" when the policy only pays up to a limited amount of expenses. Instead, the term "charge" or substantially similar language shall be used that does not have misleading or deceptive effect of the phrase "actual charges".

k. "Preexisting condition" shall not be defined to be more restrictive than the following: "Preexisting condition means a condition for which medical advice, diagnosis, care or treatment was recommended or received from a physician within the 6 month period preceding the effective date of coverage of an insured person."

l. Coverage for specified diseases shall not be excluded due to a preexisting condition for a period greater than 6 months following the effective date of coverage of an insured person unless the preexisting condition is specifically excluded.

m. Hospice Care.

1. "Hospice" means a facility licensed, certified or registered in accordance with state law that provides a formal program of care that is:

(i) For terminally ill patients whose life expectancy is less than 6 months;

(ii) Provided on an inpatient or outpatient basis; and

(iii) Directed by a physician.

2. Hospice care is an optional benefit. However, if a specified disease insurance product offers coverage for hospice care, it shall meet the following minimum standards:

(i) Eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectancy of 6 months or less;

(ii) A fixed-sum payment of at least \$50 per day; and

(iii) A lifetime maximum benefit limit of at least \$10,000.

3. Hospice care does not cover nonterminally ill patients who may be confined in a:

(i) Convalescent home;

(ii) Rest or nursing facility;

(iii) Skilled nursing facility;

(iv) Rehabilitation unit; or

(v) Facility providing treatment for persons suffering from mental diseases or disorders or care for the aged or substance abusers.

(3) The following minimum benefits standards apply to non-cancer coverages:

a. Coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of \$250 and an overall aggregate benefit limit of no less than \$10,000 and a benefit period of not less than 2 years for at least the following incurred expenses:

1. Hospital room and board and any other hospital furnished medical services or supplies;
2. Treatment by a legally qualified physician or surgeon;
3. Private duty services of a registered nurse (R.N.);
4. X-ray, radium and other therapy procedures used in diagnosis and treatment;
5. Professional ambulance for local service to or from a local hospital;
6. Blood transfusions, including expense incurred for blood donors;
7. Drugs and medicines prescribed by a physician;
8. The rental of an iron lung or similar mechanical apparatus;
9. Braces, crutches and wheelchairs as are deemed necessary by the attending physician for the treatment of the disease;
10. Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and
11. May include coverage of any other expenses necessarily incurred in the treatment of the disease.

b. Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than \$25,000 payable at the rate of not less than \$50 a day while confined in a hospital and a benefit period of not less than 500 days.

(4) A policy that provides coverage for each insured person for cancer-only coverage or in combination with one or more other specified diseases on an expense incurred basis for services, supplies, care and treatment of cancer, in amounts not in excess of the usual and customary charges, with a deductible amount not in excess of \$250, and an overall aggregate benefit limit of not less than \$10,000 and a benefit period of not less than 3 years shall provide at least the following minimum provisions:

a. Treatment by, or under the direction of, a legally qualified physician or surgeon;

b. X-ray, radium chemotherapy and other therapy procedures used in diagnosis and treatment;

c. Hospital room and board and any other hospital furnished medical services or supplies;

d. Blood transfusions and their administration, including expense incurred for blood donors;

e. Drugs and medicines prescribed by a physician;

f. Professional ambulance for local service to or from a local hospital;

g. Private duty services of a registered nurse provided in a hospital;

h. May include coverage of any other expenses necessarily incurred in the treatment of the disease; however, subparagraphs a., b., d., e. and g. plus at least the following also shall be included, but may be subject to copayment by the insured person not to exceed 20 percent of covered charges when rendered on an out-patient basis;

i. Braces, crutches and wheelchairs deemed necessary by the attending physician for the treatment of the disease;

j. Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and

k. Home health care that is necessary care and treatment provided at the insured person's residence by a home health care agency or by others. The program of treatment shall be prescribed in writing by the insured person's attending physician, who shall approve the program prior to its start. The physician shall certify that hospital confinement would be otherwise required.

1. A "home health care agency":

(i) is an agency approved under Medicare, or

(ii) is licensed to provide home health care under applicable state law, or

(iii) meets all of the following requirements:

i. It is primarily engaged in providing home health care services;

ii. Its policies are established by a group of professional personnel including at least one physician and one registered nurse;

iii. A physician or a registered nurse provides supervision of home health care services;

iv. It maintains clinical records on all patients; and

v. It has a full time administrator.

2. Home health includes, but is not limited to:

(i) Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse;

(ii) Part-time or intermittent home health aide services that provide support services in the home under the supervision of a registered nurse or a physical, speech or hearing occupational therapists;

(iii) Physical, occupational or speech and hearing therapy; and

(iv) Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would have been covered if the insured person had remained in the hospital.

l. Physical, speech, hearing and occupational therapy;

m. Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy and eleostomy appliances;

n. Prosthetic devices including wigs and artificial breasts;

o. Nursing home care for noncustodial services; and

p. Reconstructive surgery when deemed necessary by the attending physician.

(5) The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. These coverages shall offer insured persons:

a. A fixed-sum payment of at least \$100 for each day of hospital confinement for at least 365 days;

b. A fixed-sum payment equal to one half the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least 365 days of treatment; and

c. A fixed-sum payment of at least \$50 per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least 365 days of treatment.

(6) Benefits tied to confinement in a skilled nursing home or to receipt of home health care are optional. If a policy offers these benefits, they shall equal the following:

a. A fixed-sum payment equal to one-fourth the hospital inpatient benefit for each day of skilled nursing home confinement for at least 100 days.

b. A fixed-sum payment equal to one-fourth the hospital inpatient benefit for each day of home health care for at least 100 days.

c. Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of a covered disease is made at some later date (but not retroactive more than 30 days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease.

d. Notwithstanding any other provisions of this rule, any restriction or limitation applied to the benefits in (6)a. and (6)b. whether by definition or otherwise, shall be no more restrictive than those under Medicare.

(7) The following minimum standards apply to lump-sum indemnity coverage of any specified disease:

a. These coverages shall pay indemnity benefits on behalf of insured persons of a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within 30 days of submission to the insurer of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of \$1,000.

b. Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease with one exception. In the case of clearly identifiable subtypes with significantly lower treatments costs, lesser amounts may be payable so long as the policy clearly differentiates that subtype and its benefits.

(k) Specified Accident Coverage. "Specified accident coverage" is a policy or certificate that provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than \$1,000 for accidental death, \$1,000 for double dismemberment, \$500 for single dismemberment.

(l) Limited Benefit Health Coverage.

(1) "Limited benefit health coverage" is a policy, contract or certificate, other than a policy or contract covering only a specified disease or diseases, that provides benefits that are less than the minimum standards for benefits required under (b), (c), (d), (e), (f), (g), (i) and (k). These policies, contracts or certificates may be delivered or issued for delivery in this state only if the outline of coverage required by Ins 1901.07 (l) of this rule is completed and delivered as required by Ins 1901.07 (b) of this rule and the policy or certificate is clearly labeled as a limited benefit policy or certificate as required by Ins 1901.07 (a)(15). A policy covering a single specified disease or combination of diseases shall meet the requirements of Ins 1901.05 (j) and shall not be offered for sale as a "limited coverage."

#### **Ins 1901.07 Required Disclosure Provisions.**

(a) General Rules.

(1) All applications for coverages specified in Ins 1901.06 (b), (c), (d), (e), (g), (i), (j), (k) and (l) shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the hearings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:

"The [policy] [certificate] provides limited benefits. Review your [policy] [certificate] carefully."

(2) All applications for dental plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the hearings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:

"The [policy] [certificate] provides dental benefits only. Review your [policy] [certificate] carefully."

(3) All applications for vision plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:

"The [policy] [certificate] provides vision benefits only. Review your [policy] [certificate] carefully."

(4) Each policy of individual or group supplemental accident and health insurance shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(5) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is required by law. The signature requirements in this paragraph apply to group supplemental health insurance certificates only where the certificateholder also pays the insurance premium.

(6) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy or certificate.

(7) A policy or certificate that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of the terms and an explanation of the terms in its accompanying outline of coverage.

(8) If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as "Preexisting Condition Limitations."

(9) All accident-only policies and certificates shall contain a prominent statement on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size of type used for headings or captions of sections in the policy or certificate, a prominent statement as follows:

"Notice to Buyer: This is an accident-only [policy] [certificate] and it does not pay benefits for loss from sickness. Review your [policy] [certificate] carefully."

(10) Accident-only policies and certificates that provide coverage for hospital or medical care shall contain the following statement in addition to the Notice to Buyer in (9) above:

"This [policy] [certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."

(11) All policies and certificates, except single-premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed on the first page of

the policy or certificate or attached to it stating in substance that the policyholder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder is not satisfied for any reason.

(12) If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy or certificate as originally issued, that fact shall be prominently set forth in the outline of coverage.

(13) If a policy or certificate contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall be "Conversion Privilege" or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage shall be as provided on a policy form then being used by the insurer for that purpose.

(14) Outlines of coverage delivered in connection with policies defined in this rule as hospital confinement indemnity, specified disease, or limited benefit health coverages to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of subsections (f) and (j), the following language, which shall be printed on or attached to the first page of the outline of coverage:

"This IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare review the Guide to Health Insurance for People With Medicare available from the company."

a. An insurer shall deliver to persons eligible for Medicare any notice required under Ins 1905.16 (d).

(15) Insurers, except direct response insurers, shall give a person applying for cancer insurance a The NAIC's 'A Shopper's Guide To Cancer Insurance' at the time of application enrollment and shall obtain all recipient's written acknowledgement of the guide's delivery. Direct response insurers shall provide the NAIC's 'A Shopper's Guide to Cancer Insurance' upon request but not later than the time that the policy or certificate is delivered.

(16) All specified disease policies and certificates shall contain on the first page or attached to it in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate, a prominent statement as follows:

"Notice to Buyer: This is a specified disease [policy] [certificate]. This [policy] [certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your [policy] [certificate] carefully with the outline of coverage and the Buyer's Guide."

(17) All hospital confinement indemnity policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy] [certificate] the following:

"Notice to Buyer: This is a hospital confinement indemnity [policy] [certificate]. This [policy] [certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."

(18) All limited benefit policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either

contrasting color or in boldface type at least equal to the size type use for headings or captions of sections in the [policy] [certificate] the following:

"Notice to Buyer: This is a limited benefit health [policy] [certificate]. This [policy] [certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."

(19) All basic hospital expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy] [certificate] the following:

"Notice to Buyer: This is a basic hospital expense [policy] [certificate]. This [policy] [certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage."

(20) All basic medical-surgical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy] [certificate] the following:

"Notice to Buyer: This is a basic medical-surgical expense [policy] [certificate]. This [policy] [certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage."

(21) All basis hospital/medical-surgical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy] [certificate] the following:

"Notice to Buyer: This is a basic hospital/medical-surgical expense [policy] [certificate]. This [policy] [certificate] provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage."

(22) All individual basic medical expense policies shall display prominently by type, stamp or other appropriate means on the first page of the policy, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy the following:

"Notice to Buyer: This is an individual basis medical expense policy. This policy provides benefits that are not as comprehensive as individual major medical expense coverage and should not be considered a substitute for comprehensive health insurance coverage."

(23) All dental plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy] [certificate] the following:

"Notice to Buyer: This [policy] [certificate] provides dental benefits only."

(24) All vision plan polices and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy] [certificate] the following:

"Notice to Buyer: This [policy] [certificate] provides vision benefits only."

(b) Outline of Coverage Requirements.

(1) An insurer shall deliver an outline of coverage to an applicant or enrollee in the sale of individual accident and health insurance, group supplemental health insurance, dental plans and vision plans as required in Ins 1901.05.

(2) If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement in no less than 12 point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon [application] [enrollment], and the coverage originally applied for has not been issued."

(3) The appropriate outline of coverage for policies or contracts providing hospital coverage that only meets the standards of Ins 1901.06 (b) shall be that statement contained in Ins 1901.06 (c). The appropriate outline of coverage for policies providing cover that meets the standards of both Ins 1901.05 (b) and (c) shall be the statement contained in Ins 1901.07 (e). The appropriate outline of coverage for policies providing coverage which meets the standards of both Ins 1901.06 (b) and (e) or Ins 1901.06 (c) and (e) or Ins 1901.06 (b) (c) and (e) shall be the statement contained in Ins 1901.07 (g).

(4) In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage shall be submitted to the commissioner for prior approval.

(5) Advertisements may fulfill the requirements for outlines of coverage if they satisfy the standards specified for outlines of coverage in this rule.

(c) Basic Hospital Expense Coverage (Outline of Coverage). An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Ins 1901.06 (b). The items included in the outline of coverage shall appear in the sequence prescribed:

[COMPANY NAME]

BASIC HOSPITAL EXPENSE COVERAGE

THIS [POLICY] [CERTIFICATE] PROVIDES LIMITED BENEFITS AND  
SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR  
COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

Read Your [Policy] [Certificate] Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!

(1) Basic hospital coverage is designed to provide, to persons insured, coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services and hospital outpatient services,

subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or unlimited hospital expenses.

(2) A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

- a. Daily hospital room and board;
- b. Miscellaneous hospital services;
- c. Hospital out-patient services; and
- d. Other benefits, if any.

(3) A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (2) above.

(4) A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(d) Basic Medical-Surgical Expense Coverage (Outline of Coverage). An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Ins 1901.06  
(c). The items included in the outline of coverage shall appear in the sequence prescribed:

[COMPANY NAME]

#### BASIC MEDICAL-SURGICAL EXPENSE COVERAGE

THIS [POLICY] [CERTIFICATE] PROVIDES LIMITED BENEFITS AND  
SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR  
COMPREHENSIVE HEALTH INSURANCE COVERAGE

#### OUTLINE OF COVERAGE

(1) Read Your [Policy] [Certificate] Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control your policy. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!

(2) Basic Medical-Surgical expense coverage is designed to provide, to persons insured, coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for hospital expenses fees or unlimited medical-surgical expenses.

(3) A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

- a. Surgical services;
- b. Anesthesia services;
- c. In-hospital medical services; and
- d. Other benefits, if any.

(4) A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.

(5) A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(e) Basic Hospital/Medical-Surgical Expense Coverage (Outline of Coverage). An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Ins 1901.06 (b) and (c). The items included in the outline of coverage shall appear in the sequence prescribed.

[COMPANY NAME]

#### BASIC HOSPITAL/MEDICAL-SURGICAL EXPENSE COVERAGE

THIS [POLICY] [CERTIFICATE] PROVIDES LIMITED BENEFITS AND  
SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR  
COMPREHENSIVE HEALTH INSURANCE COVERAGE

#### OUTLINE OF COVERAGE

(1) Read Your [Policy] [Certificate] Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY.

(2) Basic hospital/medical-surgical expense coverage is designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical surgical expenses.

(3) A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

- a. Daily hospital room and board;
- b. Miscellaneous hospital services;
- c. Hospital outpatient services;
- d. Surgical services;
- e. Anesthesia services;
- f. In-hospital medical services; and
- g. Other benefits, if any.

(4) A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.

(5) A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to charge premiums.

(f) Hospital Confinement Indemnity Coverage (Outline of Coverage). An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Ins 1901.06 (e). The items included in the outline of coverage shall appear in the sequence prescribed:

[ COMPANY NAME]

#### HOSPITAL CONFINEMENT INDEMNITY COVERAGE

THIS [POLICY] [CERTIFICATE] PROVIDES LIMITED BENEFITS

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO  
COVER ALL MEDICAL EXPENSES

#### OUTLINE OF COVERAGE

(1) Read Your [Policy] [Certificate] Carefully – This outline of coverage provides a very brief description of the important feature of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!

(2) Hospital confinement indemnity coverage is designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits others than the fixed daily indemnity for hospital confinement and any additional benefit described below.

(3) A brief specific description of the benefits in the following order:

- a. Daily benefit payable during hospital confinement; and
- b. Duration of benefit described in a.

(4) A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefit, described in (3) above.

(5) Any benefits provided in addition to the daily hospital benefit.

(g) Major Medical Expense Coverage (Outline of Coverage). An outline of coverage in the form prescribed below, shall be issued in connection with policies meeting the standards of Ins 1901.06 (f). The items included in the outline of coverage shall appear in the sequence prescribed:

[COMPANY NAME]

#### INDIVIDUAL MAJOR MEDICAL EXPENSE COVERAGE

#### OUTLINE OF COVERAGE

(1) Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) Individual major medical expense coverage is designed to provide, to persons insured, comprehensive coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

(3) A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:

- a. Daily hospital room and board;
- b. Miscellaneous hospital services;
- c. Surgical services;
- d. Anesthesia services;
- e. In-hospital medical services;
- f. Out-of-hospital care;
- g. Maximum dollar amount for covered charges; and
- h. Other benefits, if any.

(4) A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.

(5) A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(h) Individual Basic Medical Expense Coverage (Outline of Coverage). An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Ins 1901.06(g). The items included in the outline of coverage shall appear in the sequence prescribed:

[COMPANY NAME]

#### INDIVIDUAL BASIC MEDICAL EXPENSE COVERAGE

##### OUTLINE OF COVERAGE

(1) Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) Individual basic medical expense coverage is designed to provide, to persons insured, limited coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other

limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

(3) A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:

- a. Daily hospital room and board;
- b. Miscellaneous hospital services;
- c. Surgical services;
- d. Anesthesia services;
- e. In-hospital medical services;
- f. Out-of-hospital care;
- g. Maximum dollar amount for covered charges; and
- h. Other benefits, if any.

(4) A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.

(5) A description of policy provisions respecting renewability or continuation of coverage, including age restrictions of any reservation of right to change premiums.

(i) Disability Income Protection Coverage (Outline of Coverage). An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Ins 1901.06 (h). The items included in the outline of coverage shall appear in the sequence prescribed:

[COMPANY NAME]

#### DISABILITY INCOME PROTECTION COVERAGE

##### OUTLINE OF COVERAGE

(1) Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) Disability income protection coverage is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(3) A brief specific description of the benefits contained in this policy.

(4) A description of any policy provisions that exclude, eliminate, restrict, reduce, limit delay or in any other manner operate to qualify payment of the benefits described in (3) above.

(5) A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(j) Accident-Only Coverage (Outline of Coverage). An outline of coverage in the form prescribed below shall be issued in connection with policies meeting the standards of Ins 1901.06(i). The items included in the outline of coverage shall appear in the sequence prescribed:

[COMPANY NAME]

ACCIDENT-ONLY COVERAGE

THIS [POLICY] [CERTIFICATE] PROVIDES LIMITED BENEFITS

BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO  
COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

(1) Read Your [Policy] [Certificate] Carefully – This outline of coverage provides a very brief description of the important features of the coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!

(2) Accident-only coverage is designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(3) A brief specific description of the benefits contained in this policy.

(4) A description of any policy provisions that exclude, eliminate, restrict, reduce, limit delay or in any other manner operate to qualify payment of the benefits described in (3) above.

(5) A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(k) Specified Disease or Specified Accident Coverage (Outline of Coverage). An outline of coverage in the form prescribed below shall be issued in connection with policies or certificates meeting the standards of Ins 1901.06(j) and (k). The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage shall appear in the sequence prescribed:

[COMPANY NAME]

[SPECIFIED DISEASE] [SPECIFIED ACCIDENT] COVERAGE

THIS [POLICY] [CERTIFICATE] PROVIDES LIMITED BENEFITS

BENEFITS PROVIDED ARE SUPPLEMENTAL AND  
ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

(1) This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it. Read the Buyer's Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage.

(2) Read Your [policy] [certificate] [Outline of Coverage] Carefully – This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!

(3) [Specified disease] [Specified accident] coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of [specified diseases] or [specified accidents]. Coverage is not provided for basis hospital, basic medical-surgical, or major medical expenses.

(4) A brief specific description of the benefits, including dollar amounts.

(l) Limited Benefit Health Coverage (Outline of Coverage). An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates which do not meet the minimum standards of Ins 1901.06 (b), (c), (d), (e), (f), (g), (i) and (k). The items included in the outline of coverage shall appear in the sequence prescribed:

[COMPANY NAME]

#### LIMITED BENEFIT HEALTH COVERAGE

BENEFITS PROVIDED ARE SUPPLEMENTAL AND  
ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

#### OUTLINE OF COVERAGE

(1) Read Your [policy] [certificate] Carefully – This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!

(2) Limited benefit health coverage is designed to provide, to persons insured, limited or supplemental coverage.

(3) A brief specific description of the benefits, including dollar amounts.

(4) A description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.

(5) A description of any provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(m) Dental Plans (Outline of Coverage). An outline of coverage in the form prescribed below shall be used in connection with dental plan policies and certificates. The items included in the outline of coverage shall appear in the sequence prescribed:

(1) Read Your [policy] [certificate] Carefully – This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!

(2) A brief specific description of the benefits.

(3) A description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (2) above.

(4) A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(n) Vision Plans (Outline of Coverage). An outline of coverage in the form prescribed below shall be issued in connection with vision plan policies and certificates. The items included in the outline of coverage shall appear in the sequence prescribed:

(1) Read Your [policy] [certificate] Carefully – This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR [POLICY] [CERTIFICATE] CAREFULLY!

(2) A brief specific description of the benefits.

(3) A description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (2) above.

(4) A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

**Ins 1901.08 Requirements for Replacement of Individual Accident and Health Insurance.**

(a) An application form shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and health insurance presently in force. A supplementary application or other form to be signed by the applicant containing the question may be used.

(b) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in (c) below. The insurer shall retain a copy of the notice. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in (d) below. In no event, however, will the notices be required in the solicitation of the following types of policies: accident-only and single-premium nonrenewable policies.

(c) The notice required by (b) above for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT  
OF ACCIDENT AND HEALTH INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by [insert company name] Insurance Company. For your own information and protection you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Application" was delivered to me on:

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Applicant's Signature)

(d) The notice required by subparagraph (b) for a direct response insurer shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT  
OF ACCIDENT AND HEALTH INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by [insert company name] Insurance Company. Your new policy provides 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

(1) Health conditions that you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) [To be included only if the application is attached to the policy]. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [insert company name and address] within 10 days if any information is not correct and complete, or if any past medical history has been left out of the application.

[COMPANY NAME]

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